Royal College of General Practitioners

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Second Reading of The Terminally Ill Adults (End of Life) Bill

House of Lords, Friday 12 September 2025

RCGP Position on Assisted Dying

On 14 March 2025, the RCGP UK Council voted to move to a position of neither supporting nor opposing assisted dying being legal. The UK Council debate and subsequent decision was informed by an all-member survey that ran between January and February 2025.

In September 2024, UK Council agreed a set of principles, based on recommendations that should be applied if legislation is introduced to legalise assisted dying. These principles have fed into the College's ongoing influencing activity in response to the current legislative developments to ensure that any changes to the law protect the interests of all patients and healthcare professionals.

Further information, including copies of all our previous briefings and submissions can be found at: www.rcgp.org.uk/representing-you/policy-areas/assisted-dying

Our principle	What the Bill says	What the RCGP wants
Any assisted dying service should be seen as a standalone specialised service that GPs and other healthcare professionals may opt in to provide, with additional training and should not be deemed core GP work.	At present, there is nothing in the Bill itself about how an assisted dying service might be delivered, only that the Secretary of State must ensure arrangements are in place for assistance to be provided in accordance with the Bill. The Bill says that people will be directed to information, but currently gives no indication of what that information would be, or how this might be delivered. While the Bill Sponsors have said that the Bill includes an opt-in model for doctors, the wording of the proposed legislation as it stands does not use this language. Indeed, the Bill's supporting impact assessment (IA) uses "opt out" language throughout.	Whilst it is not the role of the RCGP to design exactly how this standalone service would operate in practice, we do not believe it is appropriate or practical for this to sit within the existing core responsibilities of general practice. The establishment of a separate service which covered every stage of the process, including the provision of impartial information, would ensure healthcare professionals of multiple disciplines (including GPs) can **opt-in** to provide assisted dying services, arranged through a different pathway. This separate service would also be able to provide the wrap-around services patients and their families need.

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		We believe it is essential that there is further clarification on the face of the Bill that participation is not presumed and that it will be truly **opt-in**. We continue to call for confirmation, on the face of the Bill, that assisted dying will be commissioned as a separate service. At a minimum, we are calling for a clear ministerial commitment that any assisted dying service would be a standalone separate service with a dedicated separate pathway and not considered core GP work.
There should be a right for GPs to refuse to participate in the assisted dying process on any ground, and statutory protection making it unlawful to discriminate against them for doing so.	The Bill has a general and comprehensive right to refuse. This ensures that there is no duty on any person to take part in the Bill's provisions (either in the provision of assisted dying or in a supporting role) if they choose not to, for whatever reason. We welcome the recent addition of New Clause 10 agreed at Report Stage, to deliver on a commitment to tighten the wording of this section of the Bill to prevent any ambiguity over its scope. We also support the new provision that a doctor who does not wish to take part will not have to 'refer' a patient who is requesting an assisted death – instead, they must direct the person to where they can obtain information and have the preliminary discussion (mirroring professional obligations regarding abortion provision). This was a specific amendment the College called for in both our written and oral evidence to the Bill Committee.	As different legislation is developing separately across different jurisdictions, it is important that Parliament considers how to protect doctors in one jurisdiction who might be supporting people in another jurisdiction where the law on assisted dying might be different. We would therefore like to see a Ministerial commitment, to amend the Suicide Act 1961 (in Clause 29) to ensure no medical professional is criminalised for the provision of assistance in accordance with current (or future) assisted dying legislation in the rest of the UK and/or Crown Dependencies.

An independent and transparent system of oversight, monitoring and regulation should be established.	The current wording of the Bill says that any assisted dying service should be reviewed by the Secretary of State 5 years after the legislation has received Royal Assent. In our written submission to the Bill Committee, we called for more data to be collected on those patients using any assisted dying service to help identify any trends, particularly related to deprivation, gender and ethnicity. The legislation has now been amended to make it clear that a person's ethnicity, gender and postcode must now be collected. A Voluntary Assisted Dying Commissioner is set up as part of the Bill. The Commissioner must monitor the operation of the Act, including compliance with its provisions and any regulations or code of practice made under it, investigate, and report to an appropriate national authority on, any matter connected with the operation of the Act.	There should be a routine review of all individual assisted deaths – including ensuring the process was followed correctly and ruling out hidden coercion. Common in other jurisdictions, this process can provide additional scrutiny and lead to improved service delivery and governance. Data about all assisted deaths needs to be collected centrally, and for aggregated data to be published on a regular basis. There needs to be a formal mechanism set up to analyse this information (from all assisted deaths), with a view to making recommendations about how the system could be improved to ensure the compassionate, safe, and practical operation of the Act.
There should be a full and extensive consultation on defining the regulatory framework, standards and training for all those involved in delivering assisted dying services. Work to define standards and training for those involved in delivering assisted dying services would need to be conducted on a cross College, multi-professional basis.	A legal 'duty to consult provision' requires the Secretary of State to identify and consult such persons they consider appropriate, prior to making regulations related to the Bill. There is a legal duty on the Secretary of State to set training, qualifications, and experience requirements for co-ordinating and independent doctors. A requirement for the registered medical practitioner acting as the coordinating and independent doctor to have undertaken	It is important that any training is proportionate and appropriate. Only those who are willing to opt in to be involved in the process should have the full specialist training. It should also form part of the annual appraisal process for GMC revalidation. Any training would need to prepare participating healthcare professionals for and cover all elements of the provision of assisted dying, including but not limited to capacity assessment, coercion identification, safeguarding, mental health

	training on domestic abuse, including coercive control and financial abuse.	support, medication and prescribing decision making, and death and certification. The time commitment and emotional toll on professionals involved in assisted dying must be acknowledged. All medical professionals opting to provide the service should be able to access funded mental health support. There needs to be more clarity, either on the face of the bill or verbal commitment from a Minister, that the duty to consult will be extensive, meaningful and include all relevant medical bodies and patient representative groups with a particular focus on marginalised groups. A further commitment should be given that should the Bill proceed, all regulations brought before Parliament will be given full and considered scrutiny.
Any assisted dying service would need to be separately and adequately resourced and should not, in any way, result in a de-prioritisation of core general practice, or palliative care services.	The Bill says that that the Secretary of State must ensure arrangements are in place for the funding of any provision made. The impact assessment for the Bill suggests assisted dying would be free at the point of delivery. If a registered medical practitioner conducts a preliminary discussion with a person, the practitioner must explain to and discuss with that person all appropriate palliative, hospice or other care, including symptom management and psychological support, and offer to refer them to a registered medical practitioner who specialises in such care for the purpose of further discussion. The Secretary of State is required to publish an assessment of the availability, quality and	It is essential to ensure that every patient approaching the end of life has access to high-quality palliative care—regardless of where they live, or their background. The government's own Equality Impact Assessment notes that regional disparities in access to palliative care risk leading some individuals to consider assisted dying when they might not have done so if appropriate care had been available. We are calling for Government to make a clear commitment that funding for any assisted dying service would be additional to that already outlined for the NHS and would not result in a de-prioritisation of core general practice, or palliative care services.

	distribution of palliative and end of life care services as part of the first report on implementation of the Act (to be undertaken within 1 year of the Act being passed).	We continue to urge Peers to push Ministers to make further clear commitments around the expansion of palliative and end of life care provision and to ensure access is truly equitable.